

Clinical Policy: Dichlorphenamide (Keveyis)

Reference Number: HIM.PA.SP44

Effective Date: 12.01.17

Last Review Date:

Line of Business: Health Insurance Marketplace

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Dichlorphenamide (Keveyis[®]) is an oral carbonic anhydrase inhibitor.

FDA Approved Indication(s)

Keveyis is indicated for primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants.

Policy/Criteria

Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria

A. Hyperkalemia/Hypokalemia Periodic Paralysis and Variants (must meet all):

1. Diagnosis of primary hyperkalemic or hypokalemic periodic paralysis, and related variants (i.e.: Andersen's syndrome, Paramyotonia congenita);
2. Failure of acetazolamide, unless contraindicated or clinically significant adverse effects are experienced;
3. Dose does not exceed 200 mg (4 tablets) per day.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Hyperkalemia/Hypokalemia Periodic Paralysis and Variants (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (example: reduced frequency of paralysis);
3. If request is for a dose increase, new dose does not exceed 200 mg (4 tablets) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

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- Approval duration: Duration of request or 12 months (whichever is less); or**
2. Refer to HIM.PA.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PHAR.21 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

V. References

1. Keveyis Prescribing Information. Hawthorne, NY: Taro Pharmaceuticals U.S.A, Inc.; January 2017. Available at <https://keveyis.com/keveyis-prescribing-information.pdf><https://keveyis.com>. Accessed on August 18, 2017.
2. Tawil R, McDermott MP, Brown R, et al. Randomized trials of dichlorphenamide in the periodic paralyses. *Ann Neurol* 2000;47:46-53
3. Venance SL, Cannon SC, Fialho D, et al. The primary periodic paralyses: diagnosis, pathogenesis and treatment. *Brain* 2006; 129:8.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.01.17	11.17

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

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contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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